

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11287

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Boots Motel Central & Garrison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community One day
years, months or days)

3. (a) PRINT FULL NAME CARL Anderson

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Annabelle Anderson 6. (c) Age of husband or wife if alive 33 years
7. Birth date of deceased December 7, 1914
(Month) (Day) (Year)

8. AGE: Years 53 Months 3 Days 3 If less than one day

9. Birthplace Goodland, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Construction Worker

11. Industry or business

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Max Carl Anderson
(b) Address Mountain View, Mo.

17. (a) Burial (b) Date thereof Mar. 8, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Cemetery

18. (a) Signature of funeral director J. W. Knell
(b) Address Carthage, Mo.

19. (a) Mar. 8, 1945 (b) E. J. McIntire, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Pennsylvania (b) County Somerset
(c) City or town Somerset
(If outside city or town limits, write "RURAL")
(d) Street No. Unknown
(If rural, give location)
(e) If foreign born, how long in U. S. A. Unknown years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 7,
year 1945 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from March 7, 1945 to March 7, 1945;
that I last saw him alive on March 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Black Heart Duration

Due to 95W

Due to 95W

Other conditions 95W
(Include pregnancy within 3 months of death)

Major findings:
Of operations 95W

Of autopsy Investigation

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 95W
(b) Date of occurrence 95W
(c) Where did injury occur? 95W
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
95W

While at work? 95W (Specify type of place)
(e) Means of injury 95W

23. Signature R. T. Winchester (M. D. or other)
Address Jasper, Mo. Date signed 3-2-45

See affidavit no 261 in Mike file 11940
RECEIVED

District Health Officer No. 6,

District File Number 440-1180

Date Filed APR 1 5 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed P. W. K. Miller

Licensed Embalmer No. 814

P. O. Address Carthage Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.